

# Frequent Touch Primary Care & CV Disease Prevention


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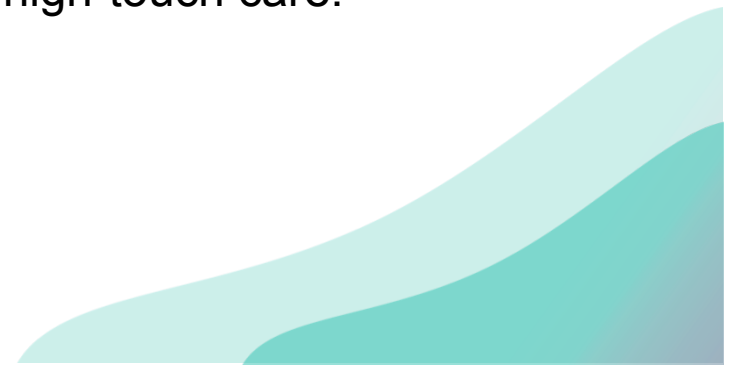
**After viewing this presentation, you should be able to:**

- **Define High Touch Care**
- **Define Value-Based Care**
- **Have a better understanding of value-based care**
- **Appreciate the difference between a value-based high-touch model versus a standard model and the impact on hospitalization and cost**

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- 46 million people are 65 years or older in the United States.
  - Elderly population is expected to double by 2030.
  - Caring for chronic conditions in this age group costs the United States more than \$617 billion/yr.



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- High-intensity care is defined as “care provided by a multidisciplinary team for patients with complex conditions to improve care and lower healthcare costs.”
  - An emerging name for this model subtype is high-touch care.



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## **High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population**

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## Study Details



Retrospective cohort study  
of 2 models of care



Model 1: high touch care  
model – smaller panel size  
+ more frequent visits.



Model 2 – Standard care  
model.



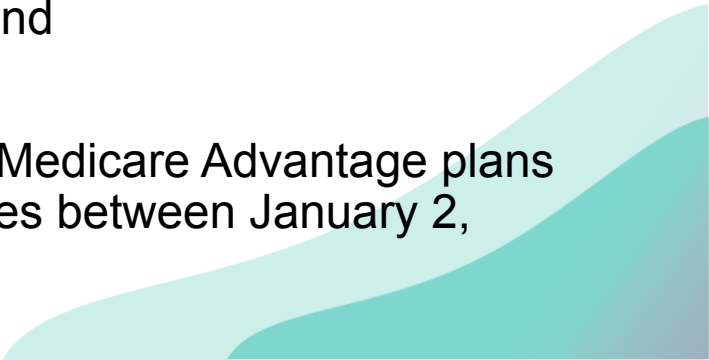
## Model 1

Chen Senior Medical Centers is a multispecialty organization spread over 8 states.

Its model of care is based on the following pillars:

- A preventive cardiovascular program
- In most states, on-site medication dispensing by providers
- Smaller patient panels of approximately 450 patients per primary care physician (PCP)
- Very frequent encounters, mean of 189 mins/yr. face time
- An advanced electronic health record (EHR) system
- Courtesy transportation for all patients and
- Walk-in hours.

We included all Chen Medical members who had Medicare Advantage plans and were seen in any of the Chen Medical practices between January 2, 2014, and March 27, 2015.



**TABLE 1.** Comparisons Between Models of Care

Service	Model 1: High-Touch Care	Model 2: Standard Care
Number of offices	>20	3
Preventive cardiovascular program	Yes	No
Electronic health record	Yes, without patient access	Yes, with patient access
Urgent care	No	Yes
Laboratory and imaging	No	Yes
Onsite medication dispensing	Yes	Yes
PCP panel	450 patients	1000 patients
Average yearly face time with PCP	189 minutes	90 minutes
Transportation	Yes	No

PCP indicates primary care physician.







## Study Details



17,711 unmatched Medicare Advantage primary care patients included



Matched 5695 patients from both models of care



Charlson comorbidity Index, age + gender were similar between both matched groups ( $P > .05$ )

**TABLE 3.** Propensity-Matched Baseline Characteristics

Characteristic	Model 1: High-Touch Care	Model 2: Standard Care	<i>P</i>
n	2356	3339	
CCI score, mean ± SD	0.33 ± 0.72	0.35 ± 0.72	.06
Age, years, mean ± SD	71.1 ± 3.6	71.2 ± 3.5	.07
Female, %	57	59	.16
Number of PCP patient visits per year, mean ± SD	8.7 ± 4.6	3.8 ± 3.8	<.01

CCI indicates Charlson Comorbidity Index; PCP, primary care physician.



**TABLE 4.** Medication Use in Matched Models of Care

Medication	Model 1: High-Touch Care	Model 2: Standard Care	<i>P</i>
Aspirin, %	41	0	<.01
ACE inhibitor/ARB, %	69	33	<.01
β-Blocker, %	39	17	<.01
Statin, %	64	42	<.01
Diuretic, %	51	24	<.01

ACE indicates angiotensin-converting enzyme; ARB, angiotensin receptor blocker.





## Primary Outcomes



Primary outcome was healthcare utilization.



Healthcare utilization = total healthcare costs + number of hospital admissions.



We collected medical, pharmacy, hospital admissions during the same 15-month period; and counted all admissions to any hospital.



## Secondary Outcomes

A secondary outcome was use of medications.

We defined medication use as refilling at least 1 prescription in each of those medication classes during the study period.

The background of the slide is an abstract composition of overlapping, wavy shapes in various shades of purple, magenta, and blue. The colors transition from a deep purple at the top to a lighter magenta in the middle, and finally to a dark blue at the bottom. The shapes are fluid and organic, creating a sense of movement and depth.

# Results

**TABLE 5.** Healthcare Utilization by Model of Care

Characteristic	Model 1: High-Touch Care (n = 2356)	Model 2: Standard Care (n = 3339)	P
Median (95% CI) PMPM total costs removing 5% outliers on both tails, \$	87 (26-278)	121 (52-284)	<.01
Number of hospital admissions per year, mean ± SD	0.10 ± 0.45	0.20 ± 0.58	<.01
Median (IQR) PMPM total costs removing 5% outliers on lower tail, \$	51 (0-184)	84 (25-269)	<.01
Adjusted mean (95% CI) PMPM costs, \$	361 (105-956)	435 (206-1356)	<.01

IQR indicates interquartile range; PMPM, per member per month.



 **Model 1 vs. Model 2**

Median Total PMPM Health Care Costs	
Model 1	Model 2
\$87 (95% CI, \$26 – \$278)	\$121 (95% CI, \$52 - \$284)

**Model 2's total PMPM costs were ~39% higher!!**

Mean Number of Hospital Admissions	
Model 1	Model 2
0.10 ± 0.40	0.20 ± 0.58

**Model 1's mean # of hospitalizations were ~50% lower!!!!**



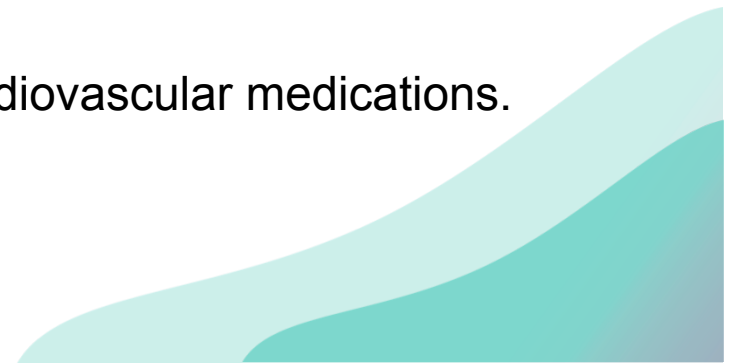




## High-Touch Care

Patients who received high-touch care had:

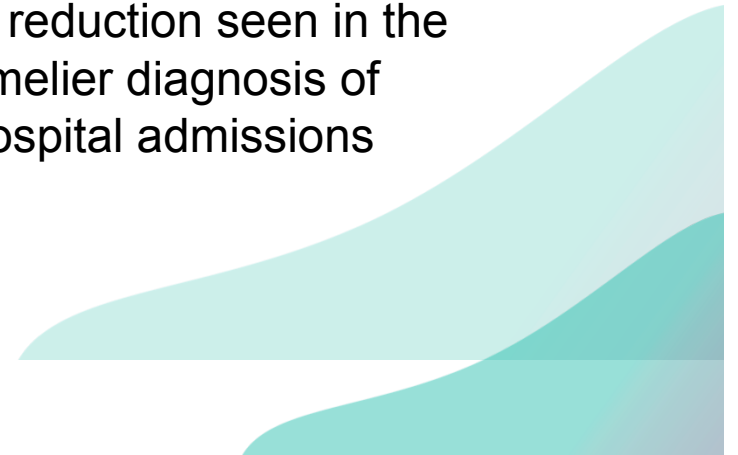
- Lower healthcare costs
- Fewer hospitalizations
- Had a higher number of encounters between patients and providers
- Was associated with higher use of cardiovascular medications.





## High-Touch Care

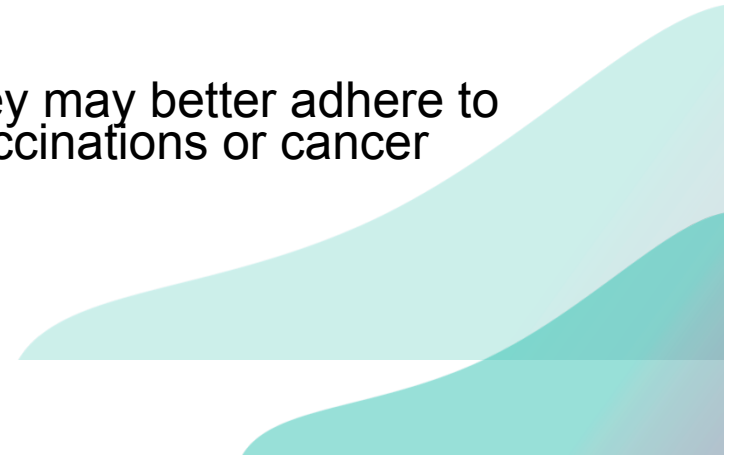
- Common causes for hospitalization due to common ambulatory care–sensitive conditions (ACSCs) include
  - lack of or delayed access to care
  - suboptimal monitoring
  - medication nonadherence.
- A potential explanation for the healthcare cost reduction seen in the high-touch model is that it may allow for the timelier diagnosis of ACSCs, leading to a lower mean number of hospital admissions





## High-Touch Care

- Greater interaction between patients and providers may allow for better optimization of medications and promote better adherence, leading to higher use of evidence-based medications.
- Our findings support the fact that the high-touch model may lead to higher use of cardiovascular medications known to improve control of blood pressure and cholesterol and improve cardiovascular outcomes.
- When patients are seen more frequently, they may better adhere to other preventive care strategies, such as vaccinations or cancer screenings.





## Limitations

- We matched for a limited number of factors known to affect the outcomes and could not match for other variables such as cardiovascular risk, social determinants of health, and principal diagnosis. However, we did match for the most important contributors to costs, such as comorbidity burden and age.
- We had access only to claims data for both models of care; therefore, our analysis is subject to information bias.
- The generalizability of the results is applicable only to at-risk practices that care for Medicare Advantage populations.





## Summary...

- Trust in healthcare relationships is a key ingredient of effective and high-quality care.
- High-touch care can help build the physician–patient relationship, which in turn could lead to greater trust.

